EXHIBIT "T"

THE CLERK: The sworn witness is Katrina Kardos, K-A-R-D-O-S.

(Samaritan Hospital Emergency Room Report marked People's Exhibit 7 for identification.)

MS. EGAN: May I inquire, Your Honor?

THE COURT: Yes, you may.

DIRECT EXAMINATION

BY MS. EGAN:

Q. Good morning, Dr. Kardos.

A. Good morning.

Q. Would you introduce yourself for the jury?

A. I am Dr. Katrina Kardos. I am an emergency medicine physician at Samaritan Hospital in Troy.

Q. And how long have you practiced emergency medicine?

A. I finished medical school in 2003, and I have been working at Samaritan Hospital in the emergency room since 2006.

Q. And can you tell us --

THE COURT: I'm sorry; if I could interrupt for one moment. We are going to take a brief break at this time. Members of the jury, please don't discuss the case. Don't form any judgments or opinions. If I could ask you to step into the jury room for just one moment. Thank you.

(Jury excused.)

THE COURT: Please be seated. Dr. Kardos, if I

could ask that you please, during the course of this - what I believe will be a short break - please don't discuss your testimony or this case with anybody, including the attorneys involved in this case. If I could ask you to step out of the courtroom for just one moment. Thank you.

(Witness excused.)

THE COURT: Okay. We are outside the presence of the jury. Juror Number Eight has just indicated to the Court through the Court Officer that she is familiar with this witness from Samaritan Hospital. I have no further information other than that, but it would be the Court's intention at this time to bring Juror Number Eight out and inquire regarding what she's indicated to the Court. Are the People okay with that?

MS. BOOK: Yes, Your Honor.

THE COURT: Defense okay with that?

MR. COFFEY: Yes.

THE COURT: We will bring Juror Number Eight out, please.

(Juror Number Eight present in courtroom.)

THE COURT: Good morning, ma'am. How are you?

TRIAL JUROR: I'm well. Thank you.

THE COURT: For the record, you are Jeanine Grinage, the juror in Seat Eight, Juror Number 381. Is

that correct?

TRIAL JUROR: That's correct.

THE COURT: Ma'am, I believe you, through the Court Officer, have indicated to the Court that you are familiar with Dr. Kardos. Is that correct?

TRIAL JUROR: Yes.

THE COURT: How are you familiar with her?

TRIAL JUROR: She's treated family members at the emergency room.

THE COURT: Treated your family members?

TRIAL JUROR: Yes.

THE COURT: Has she ever treated you personally?

TRIAL JUROR: I don't know. I don't think so.

THE COURT: Okay. And when you say she's treated family members, do you know which family members in particular she's treated?

TRIAL JUROR: Yes, my niece and my nephew.

THE COURT: And were you present during any of those times that your niece or nephew were treated by Dr. Kardos?

TRIAL JUROR: Yes.

THE COURT: Do you know Dr. Kardos in any fashion, other than what you have just described?

TRIAL JUROR: No.

THE COURT: And on those occasions when your

niece or nephew were treated by her and you were present, did you have any direct interaction with her?

TRIAL JUROR: Other than being in the room? No.

THE COURT: Okay. Based upon the situation that you have just described, essentially being present while Dr. Kardos treated on various occasions your niece or your nephew, based upon that, does that have any impact on your ability to assess Dr. Kardos' testimony and her credibility?

TRIAL JUROR: No.

THE COURT: Based upon that, do you -- does Dr. Kardos have either a leg up or a leg down or would you view her testimony any differently than you would any other witness?

TRIAL JUROR: No. I really don't remember what she did, so no.

THE COURT: Okay. Based upon what you have explained to me here now, does that have any impact at all on your ability to be fair and impartial in this case?

TRIAL JUROR: No.

THE COURT: Okay. Ms. Book, any questions for this juror?

MS. BOOK: Just briefly. Was Dr. Kardos able to resolve whatever it was that they were being seen for?

TRIAL JUROR: I don't really remember. I just

recognized her when she came in and thought I was supposed to let the Judge know. But I don't remember what went on in the emergency room.

MS. BOOK: Okay. After seeing Dr. Kardos, were they ever again seen for that same issue?

TRIAL JUROR: Because I don't remember what it was, I really don't recall.

MS. BOOK: Okay. So, you didn't have a negative experience, in that you felt like she didn't treat whatever it was that they were there for that you recall?

TRIAL JUROR: No. It's neither positive nor negative. I really don't remember. I just recognized her when she came in.

MS. BOOK: Okay. Thank you.

THE COURT: Mr. Coffey, any questions?

MR. COFFEY: No.

THE COURT: Ma'am, if I could ask you to just step over in that room for one moment with the Court Officer. Thank you.

(Juror excused.)

THE COURT: People satisfied?

MS. BOOK: Yes, on that issue.

THE COURT: Defense satisfied?

MR. COFFEY: Yes.

THE COURT: Both parties consent to this juror

remaining on this jury. Therefore, with the parties' consent, and because this juror indicated that she only came in contact with Dr. Kardos on a couple of isolated incidents, only in a professional manner at that, and during those interactions, she did not directly interact with Dr. Kardos, along with the fact that this juror indicated unequivocally that she could be and would be fair and impartial and that the situation she explained to the Court would have no impact on her ability to assess Dr. Kardos' testimony or credibility, for all those reasons and, again, the parties' consent, the Court will leave this juror on the jury. Bring her back out, please.

(Juror Number Eight present in courtroom.)

THE COURT: Ma'am, I want to thank you for bringing that to my attention. I am going to leave you on the jury. I will ask that you return to the jury room at this time, but I will ask you, please don't discuss with any other jurors anything that you and I have talked about. Okay?

TRIAL JUROR: Yes, Your Honor.

THE COURT: Thank you, ma'am.

(Juror excused.)

THE COURT: Do you have something to add, Ms. Book?

MS. BOOK: I do not. I have a question. Do you

think we could have one minute to use the restroom?

THE COURT: Yes, sure. Go ahead.

(Brief recess taken.)

(Proceedings continue outside the jury with Attorneys John Turi and Carmelo Laquidera present.)

THE COURT: We will go on the record. Mr. Laquidara is present on behalf of the People, as are Ms. Book and Ms. Egan. Mr. Turi is present on behalf of the Defendant. Mr. Coffey and Mr. Frost are not in the courtroom at this time. It's my understanding that the parties wish to place something on the record.

Mr. Thomas, do you consent to -- well, I guess I don't need to ask you. Here's Mr. Coffey and Mr. Frost. I will note that all attorneys are now present in the courtroom.

Mr. Turi and/or Mr. Laquidara, do you wish to be heard at this time?

MR. LAQUIDARA: Your Honor, it's my understanding that the Court signed a subpoena that our office asked to have signed on Friday afternoon regarding any records in possession of the Rensselaer County Public Defender's Office pertaining to the representation of William Terry by the Rensselaer County Public Defender's Office.

First, Judge, I would think we would have any of

those files that the Public Defender's Office represented him on. We would have those files as the prosecuting agency in this county. Also, my understanding in my conversations with Mr. Turi this morning is that they are in possession of one file where they represented Mr. Terry, and that's the same file that we are currently in possession of. I believe it was a burglary file. Mr. Turi has assured me here this morning in our conversations that the Public Defender's Office does not have any other files pertaining to Mr. Terry, whether it's based on their representation or representation of Mr. Terry by other Public Defender's Offices or other private attorneys, and we take Mr. Turi at his word for that.

And based on that, Judge, we see no need to go forward with the subpoena.

THE COURT: Okay. Are you withdrawing the subpoena at this time?

MR. LAQUIDARA: We are, Judge.

THE COURT: Mr. Turi, anything you want to add?

MR. TURI: Nothing to add, Your Honor, other than thank you, Carmelo. I appreciate it.

THE COURT: Thank you, Mr. Turi. If I could ask you to notify the County Attorney that the return time and date of two o'clock today is now off the calendar.

MR. TURI: Thank you, Judge. I appreciate you

taking the time so we could be heard.

THE COURT: Okay. We will bring the jury back in, please.

COURT OFFICER: Jury entering.

THE COURT: Okay. Please be seated. The sworn witness remains Katrina Kardos. I will remind you that you are still under oath. Ms. Egan, you may continue whenever you are ready.

MS. EGAN: Thank you, Your Honor.

BY MS. EGAN: (Continuing)

Q. Dr. Kardos, would you tell us a little bit about your formal education? Where did you complete your undergraduate work?

A. I went to Siena College for four years and received a Bachelor of Science. I then became a paramedic for a year, and I went to Albany Medical College for medical school for four years and then completed my residency at Albany Medical Center.

Q. And what's a residency?

A. It's a training program that's specifically designed to your field of expertise.

Q. And what was your specialty during your residency?

A. Emergency medicine.

Q. And how long is a residency?

A. They range from three years and up, depending on the field.

Q. How long was yours?
A. Three years.
Q. What did you do after you completed your residency?
A. I became an attending physician at Samaritan Hospital in Troy.
Q. Now, are you board certified?
A. Yes.
Q. And what are you board certified in?
A. Board certified in emergency medicine.
Q. And what, specifically, do emergency room physicians do?
A. They see patients that arrive to the Emergency Department and try to address and identify any life-threatening conditions and treat them.
Q. What is the goal of the emergency room treatment?
A. To stabilize the patient and to get them to the level of care that they need.
Q. Is part of that goal an ultimate diagnosis?
A. No.
Q. Is part of that goal long-term treatment?
A. No.
Q. What states are you licensed to practice medicine in?
A. New York State.
Q. And when did you receive your license?
A. 2006, I believe. I would have to look back.

Q. Have you been practicing since you received your license?

A. Yes.

Q. And have you always practiced emergency medicine?

A. Yes.

Q. How many patients would you estimate you have treated to date?

A. Between 40 and 45,000.

Q. And in September of 2008, approximately how many patients had you treated up until that point?

A. Approximately 20,000.

Q. Have you taught or lectured in your field?

A. Yes.

Q. Where?

A. I lecture for various EMS agencies, fire departments, and I have done some lectures for larger EMS fields.

Q. Approximately how many lectures have you delivered?

A. Fifty.

Q. Now, I want to talk about September 21, 2008, at around nine o'clock in the morning. Were you working then?

A. Yes.

Q. Where were you working?

A. At Samaritan Hospital in the emergency room.

Q. And do you know someone by the name of M[redacted] T[redacted]

A. Yes.

Q. How do you know M[redacted]?

A. He was a patient I treated on that date.

Q. When did you first see M[redacted]?

A. When he arrived by ambulance that morning.

Q. What condition was he in when he arrived?

A. Critical.

Q. And can you describe what you mean by critical condition?

A. His life was being supported by the paramedics at the time.

Q. What do you do when you typically first encounter a critical patient in the ER?

A. We first address what we call the ABC's, which is the airway, the breathing and the circulation of the patients.

Q. Let's go one by one. How do you assess the airway?

A. We look to see if a patient can maintain their own airway, if they can keep their tongue at the back of their mouth, if there's anything in the airway that's obstructing it; and then we go on to B, or breathing. And first we assess to see if they are breathing or not, and if they are not breathing, we address it. If they are breathing, then we determine if it's adequate for them; are they breathing deep enough and enough time is permitted, and we address that.

Q. And did you assess M[redacted]for the ABC's?

A. Yes.

Q. Could M[redacted] maintain his own airway?

A. No.

Q. What does that indicate?

A. That indicates that he either has an obstruction in the airway or that he's not able to keep his airway open because of an inability to move the tongue from the back of the airway or an inability to keep the muscles from having the airway closed.

Q. Was M[redacted] conscious at the time you saw him?

A. No.

Q. Does the inability to maintain an airway increase the risk of aspiration?

A. Yes.

Q. Can you tell us, what is aspiration?

A. Aspiration is when you have saliva or fluid or material that's in your mouth that goes into your trachea, which leads to your lungs, rather than going into your esophagus, which leads to your stomach.

Q. Is the term swallowing down the wrong pipe referring to aspiration?

A. Yes.

Q. Is aspiration a common concern with emergency room patients?

A. Yes.

Q. Why?

A. Many people that come to the emergency room come to the ER because of problems with their airway or their breathing. Patients that have these problems are at risk for aspiration.

Q. And what problems can be caused by aspiration?

MR. COFFEY: Object to this unless it's relevant.

THE COURT: Ms. Egan?

MS. EGAN: Judge, I believe that it is relevant in terms of her ultimate assessment of M[redacted]'s condition.

THE COURT: The objection is overruled.

A. Answer? Can you repeat the question?

Q. Sure. What problems can be caused by aspiration?

A. Aspiration can result in aspiration pneumonia or aspiration pneumonitis, which is inflammation in the lungs.

Q. What causes the pneumonia or the inflammation?

A. It can be the material that was -- that went down into the trachea that shouldn't have been in the trachea.

Q. Can an infection enter the body because of aspiration?

A. Yes.

Q. What are some common strains of bacteria that are associated with aspiration?

A. Strep pneumo, staph aureus, haemophilus influenzae are some of the most common ones.

Q. Does being unconscious increase your risk of aspiration?

A. Yes.

Q. And can a person aspirate without showing any outward signs that they just did so?

A. Yes.

Q. Now, you said M[redacted] could not maintain his own airway. Did you do anything to assist him with that?

A. Yes. We placed an endotracheal tube, which is a plastic tube that is inserted into the trachea through the vocal cords, and that allows us to keep his airway open and provide him with oxygen through the tube.

Q. Did you note anything unusual when you intubated M[redacted]?

A. When we looked -- when I looked in the back of the airway prior to intubation, there were secretions that had pooled in the back of his airway.

Q. Let's move on to breathing. How was M[redacted]'s breathing upon arrival?

A. It was inadequate. His respiratory was too low for his age group.

Q. So, was he able to breathe on his own?

A. Minimally.

Q. And what did you do to assist him with that?

A. Initially, we used a bag valve mask, which is a plastic mask that you put over the patient's face, and there's a bag on it that you squeeze that pushes air into their lungs, and then we placed the tube into his trachea, and then that particular bag attaches to that tube and that allows us to ventilate him.

Q. And did that work for M[redacted]?

A. Yes.

Q. Now, let's talk about his circulation. Do you recall what M[redacted]'s pulse was?

A. I know it was markedly elevated. I don't know the exact number.

Q. Is there anything that I could show you that would refresh your recollection?

A. Either my chart or a list of his vital signs as a part of the chart.

MS. EGAN: Can I have one minute, Judge?

THE COURT: Sure.

(Medical Records marked People's Exhibit 8 for identification.)

MS. EGAN: Let the record reflect I'm showing People's Exhibit 8 to defense counsel. May I approach the witness, Judge?

THE COURT: You may.

Q. Dr. Kardos, I'm showing you what's been marked as

People's Exhibit 8 for identification. I'm just going to ask you to take a look at that, see if that refreshes your recollection as to M[redacted]'s pulse rate and then hand me the exhibit before you answer the question. Are you refreshed?

A. Yes.

Q. I'm taking People's 8 for ID from the witness. Now, do you recall, what was M[redacted]'s pulse rate?

A. 182.

Q. And is that a normal pulse for a four-month-old infant?

A. No. It's elevated, too high.

Q. And do you recall what M[redacted]'s blood pressure was?

A. No. I know it was low. I would have to look at the exhibit again.

MS. EGAN: Is there any objection to offering People's 8 at this time?

MR. COFFEY: No objection.

THE COURT: People's Exhibit 8 will be received in evidence at this time without objection.

(People's Exhibit 8 marked for identification received in evidence and marked People's Exhibit 8 in evidence.)

Q. Dr. Kardos, I'm handing you now what's in evidence as People's Exhibit 8. Can you take a look at that and tell us: What was M[redacted]'s blood pressure?

A. His initial blood pressure was documented at 117 over

62.

Q. And is that a normal blood pressure for a baby his age?

A. The initial blood pressure is, yes, slightly elevated.

Q. Did you take any of M[redacted]'s other vital signs upon arrival?

A. Yes, his temperature.

Q. What was his temperature?

A. 97.2 rectally.

Q. And is that a normal temperature for a baby?

A. It's slightly low.

Q. Is there anything about a patient's vital signs that can indicate an increase in intracranial pressure?

A. Yes.

Q. What are those signs?

A. Typically an elevation in blood pressure, a low or high pulse and erratic respirations.

Q. During the time you were with him, did M[redacted] exhibit those signs at any point?

A. Yes.

Q. Now, did you get any history about M[redacted] when he came in?

A. Yes.

Q. What was that?

A. The history was obtained from his mother and from the paramedics that took care of him, and the mother had told me that M[redacted] had had diarrhea and vomiting for a couple of days; and on the morning that he came to the Emergency Department, his temperature at home was 100.4.

Q. Now, would you tell us what a differential diagnosis is?

A. A differential diagnosis is a list of potential diagnoses that we as physicians develop when we first see a patient come into the Emergency Department. It's a list of things that we progressively work through to try to determine what's wrong with a patient.

Q. And why do you make a differential diagnosis?

A. As an emergency room physician, we are designed to look for and treat the acute life-threatening emergencies first. So, when someone comes in, we try to immediately think of what are the worse things that could be wrong with this patient and then try to rule those out first. So, we make that list so that we have something to kind of go through in our heads to try to rule out or rule in.

Q. Is this list made quickly?

A. Yes.

Q. Are the potential diagnoses listed in any particular order?

A. No.

Q. Did you make a list of differential diagnoses for M[redacted]?

A. Yes.

Q. What was that list?

A. Recalling by memory, the list was sepsis or septic shock, intracranial abnormality and dehydration.

Q. And when you say "intracranial abnormality," what do you mean by that?

A. Intracranial bleeding or a rise in intracranial pressure.

Q. How would that be caused?

A. There's a variety of things that can cause this; anything from trauma, infection.

Q. Would that encompass a head injury?

A. Yes.

Q. Now, what signs did M[redacted] exhibit that made you concerned about septic shock?

A. The fact that his -- so, when M[redacted] arrived, his reported temperature at home was 100.4, which is slightly elevated; the fact that he had been ill for a couple of days with vomiting and diarrhea, and there was no reported history of trauma from the parent that was in the Emergency Department. All of those things make you concerned for sepsis.

Q. What signs made you concerned about intracranial abnormality or injury?

A. Any time a child arrives in the Emergency Department with a change in their mental status, as emergency room providers, we always have to think about a head injury or trauma or abuse to a child.

Q. And what signs made you concerned about dehydration?

A. The fact that it was reported that he had had diarrhea and vomiting prior to coming.

Q. And going one by one, what did you do to treat or rule out each of these differential diagnoses?

A. For dehydration, which is easiest - so I will explain that first - we gave him intravenous fluid or fluid that goes into his vein through an IV. For sepsis, we did a variety of blood work, including blood cultures, and we provided antibiotics through the IV. And for intracranial abnormality, the next step would have been for us to do a CAT scan of his brain, but at Samaritan Hospital, he was too unstable for us to move him from the room he was in to the CAT scanner.

In addition, at Samaritan Hospital, we don't have neurosurgeons. So, if we were to do the CAT scan and it showed bleeding or a mass or it showed an abnormality, we wouldn't have been able to act on it quickly. So, again, from the point of an emergency room doctor, our goal is to get the patient to where they can get the best level of care for their age and their illness. And so, for him, it was to get him to a facility that has a Pediatric Intensive Care Unit, where they

have other physicians that can deal with those things. So, we chose to try to stabilize him in our Emergency Department and get him to the facility where he needed to go.

Q. So, were you able to perform any scans or tests to rule out intracranial injury?

A. No.

Q. Now, you stated you had done blood cultures. What did those test for?

A. Blood cultures check for the presence of bacteria in the bloodstream.

Q. Was a Gram stain done?

A. Yes.

Q. Did you receive the results of the blood cultures and/or Gram stain while you were treating M[redacted]?

A. No. It takes one to five days for those results to come back.

Q. So, why did you start antibiotics?

A. Again, my time with every patient in the Emergency Department is limited, and I have to think of every life-threatening condition that they could have. He potentially had sepsis, so we treated him with antibiotics. And if his condition -- or excuse me. Once his cultures come back, it can be determined if they need to be continued or not. So, we start them right away to prevent a situation from getting worse.

Q. Did you perform any other tests on M[redacted]?
A. We did a chest x-ray, blood work. I believe that's all.
Q. Did the blood work show his white blood cell count?
A. Yes.
Q. Do you recall what that was?
A. Yes. It was 1.0.
Q. Now, is that a normal white blood cell level for his age?
A. No, it's low.
Q. Did the blood work show his platelet count?
A. Yes.
Q. And what was that?
A. 115,000.
Q. Is that a normal level for his age?
A. It's slightly low.
Q. Now, what is DIC?
A. DIC is a condition -- the letters stands for disseminated intravascular coagulation. It's a condition in which the proteins in your body that help to control clotting get used up rapidly. As a result, you can get small clots that can form in various parts of your body. And as it progresses, when the proteins that cause clotting get used up, you can actually then bleed more excessively.
Q. What are signs of DIC? Let me rephrase that. What

are external signs of DIC?

A. External signs would be easy bruising, easy bleeding or excessive bleeding.

Q. Now, what is coagulopathy?

A. Coagulopathy is a broad term which stands for a problem with the clotting system in general.

Q. And what are external signs of coagulopathy?

A. They can be the same; bleeding, excessive bleeding, easy bruising.

Q. What's the function of platelets in your blood?

A. Platelets help your blood to clot. If you essentially envision them of being sticky cells; they stick together when there's a wound to help it stop bleeding.

Q. Did M[redacted]'s platelet level cause you concern of a risk of either DIC or coagulopathy?

A. No.

Q. Why is that?

A. Because it was so slightly low that it wasn't at a level that concerned me.

Q. What types of levels do raise your concern?

A. Levels less than 20 to 30,000.

Q. Now, did M[redacted] show any signs of bleeding?

A. No.

Q. Did you observe any bruises on M[redacted]'s body?

A. No.

Q. Now, did [redacted] have an IV in place?
A. Yes.
Q. Did he have more than one?
A. I don't recall how many he had.
Q. Did you attempt to place a central line in M[redacted]?
A. Yes.
Q. And what is a central line?
A. A central line is when we place a larger IV. We use a needle to access one of the larger central veins in the body, and the three most common spots for those are the groin, in your femoral vein; beneath your clavicle in your subclavian vein; or in your neck, in the internal jugular vein. It allows us better access in a larger vein in the body.
Q. Where did you try to put in a central line on M[redacted]?
A. In his groin, in the femoral vein.
Q. Was it successful?
A. No.
Q. Why wasn't it successful?
A. In a child so small, it can be difficult to access the vein. When you see how small a four-month-old is, you can imagine their vein is very small, and it was difficult to access. He was also in shock at the time.
Q. Did you puncture his skin with a needle?
A. Yes.

Q. Did you observe any unusual bleeding?
A. No.
Q. Did you observe any unusual bruising?
A. No.
Q. Did you observe any unusual bleeding at his IV site?
A. No.
Q. Any bruising at his IV site?
A. No.
Q. Now, you stated you performed a chest x-ray on M[redacted], as well?
A. Yes.
Q. And did you get the results of that while M[redacted] was in your care?
A. Yes.
Q. And did you review that x-ray?
A. Yes.
Q. And what were the results on that x-ray?
A. The endotracheal tube was in good position and there was no other acute abnormality identified.
Q. Were there any signs of pneumonia on the x-ray?
A. No.
Q. Did you monitor M[redacted]'s temperature?
A. Yes.
Q. What was it?
A. When he arrived, it was 97.2 rectally, and it

progressively dropped throughout his stay in our Emergency Department. Ultimately, it was 94.7 rectally before he left our Emergency Department.

Q. Were any family members at the hospital with M[redacted]?

A. Yes, his mother.

Q. What was her demeanor when she was there?

MR. COFFEY: Object as irrelevant.

THE COURT: Ms. Egan?

MS. EGAN: Judge, I do believe it's relevant, given the People's theory of this case.

THE COURT: Overruled.

A. Answer?

Q. Yes. You may answer.

A. She was very upset, clearly worried.

Q. And did you advise her of M[redacted]'s condition?

A. Yes.

Q. Were there any other family members there?

MR. COFFEY: It's irrelevant.

THE COURT: It's been asked and answered. Sustained.

Q. Did you at some point speak to M[redacted]'s father?

A. Yes.

Q. When was that?

MR. COFFEY: I object, unless she can identify his voice; then I don't object. If she can't, I want an

offer of proof as to how she can identify that it was his voice.

THE COURT: Ms. Egan?

MS. EGAN: May we approach, Judge?

THE COURT: Sure.

(Sidebar discussion held at the bench as follows:)

MS. EGAN: I anticipate that she's going to testify that the mother asked her to contact the father, provided contact information. She called and asked to speak to either M[redacted]'s father or Adrian Thomas and advised him of the child's medical condition. Certainly, if Mr. Coffey wants to cross-examine her as to her certainty, that that was Mr. Thomas she was speaking to, he can; but again, given the People's theory of this case, given that the Defendant's level of indifference to the child's condition is something we need to prove, I certainly think this is relevant, material information. Mr. Coffey can cross-examine her, as I said, as to whether she is certain that she spoke to Mr. Thomas, but I don't believe we need to prove an identification procedure.

THE COURT: So, you are not offering any statements from Mr. Thomas, rather you are offering testimony that -- as to statements that this witness made to Mr. Thomas?

MS. EGAN: I'm offering one brief statement from Mr. Thomas in which he replied "okay" in response to the child's condition.

THE COURT: Mr. Coffey?

MR. COFFEY: Judge, it's not up to me to cross-examine to find out if it's his voice. It's up to them. *People v. Ely* establishes that if you are going to identify somebody's voice, then they have to establish that it was his voice. I don't deny the fact that she called and spoke to somebody, but she can't -- but who knows who it is?

THE COURT: How do you attempt to establish that it was the Defendant this witness was speaking to?

MS. EGAN: That she was asked by the child's mother to call the Defendant. The child's mother provided the contact information; and that when she called, she asked to speak to Adrian Thomas, M[redacted] T[redacted]' father, and the person on the phone identified himself as such.

THE COURT: If you are able to lay that foundation, then I will allow the testimony. Certainly, the defense can cross-examine the witness as he sees fit, but it will require a foundation such as the one that you just made an offer of proof on. So, that's the Court's ruling.

MR. COFFEY: I would also -- this is a *Molineux*

issue which we have not addressed. In other words, if the offer of proof now -- is now being established to show he was indifferent when he was on the phone and didn't seem to care, that's *Molineux*.

MS. EGAN: Judge, that is not *Molineux*. *Molineux* encompasses bad acts. The Defendant's response of "okay" is certainly not a bad act.

THE COURT: Let me back up for a minute here. What is the relevance of this doctor calling the Defendant, advising him - assuming that she was speaking to him - advising him of what was going on and him saying "okay"? Under what theory is that in any way relevant to indifference? You tell me how that's relevant to this case.

MS. EGAN: Certainly, Judge. I anticipate that she will state that she informed Mr. Thomas that the child was most likely not going to make it and that Mr. Thomas' response to that was simply to state "okay". That is relevant to his level of indifference to the child's plight, and he hung up the phone after that without asking any follow-up questions. *People v. Barboni* indicates that the People must show the Defendant's level of indifference was depraved and I think, literally, did not care whether the child lived or died.

THE COURT: At the time he committed the acts.

MS. EGAN: Even in the hours afterwards. *Barboni* specifically talks about the acts encompassing two hours following when the Defendant abused the child.

THE COURT: When the child is still in the Defendant's care, when the Defendant is still -- has control over what's happening, not once the child is out of the Defendant's control and in the hospital. At that point in time -- what it sounds like to me you are arguing is that it goes to consciousness of guilt. His state of mind after the baby has been removed from the home and taken to the hospital is completely irrelevant with respect to depraved indifference. Depraved indifference pertains to the time that he allegedly committed the acts or in the immediate aftermath when the baby was still in his control. So, now that I understand that, I don't see any relevance to this, other than, perhaps, consciousness of guilt, which, as the parties I'm sure are aware, is weak evidence to begin with. There's many interpretations to what "okay" means. So, having understood now more fully what is being presented, I'm going to sustain the objection and not allow that. It's only relevant to consciousness of guilt, which is weak to begin with. The objection is sustained.

(Proceedings continue in open court as follows:)

THE COURT: The objection is sustained, Ms.

Egan. You may continue.

Q. Dr. Kardos, how long was M[redacted]in your care?

A. Approximately two hours.

Q. And did he leave Samaritan Hospital at some point?

A. Yes.

Q. How was that arranged?

A. I called Albany Medical Center and spoke to the pediatric intensivist and we arranged for M[redacted] to be transferred from our facility to Albany Med's Pediatric ICU by ambulance.

Q. What is a provisional diagnosis?

A. It's a diagnosis that we document before we have all of the data back.

Q. How does this differ from a differential diagnosis?

A. A differential diagnosis is a list of possibilities that we go through and try to rule out. A provisional diagnosis is things that we found, given the amount of time and data that we have in our short time that we see a patient in the ER.

Q. And did you make a provisional diagnosis of M[redacted]?

A. Yes.

Q. Do you recall what that was?

A. I would have to see the list to be accurate.

Q. Certainly.

MS. EGAN: May I approach the witness, Judge?

THE COURT: Yes, you may.

MS. EGAN: I'm showing the witness what's been marked as People's 7 for ID.

Q. If you could just take a look at that and let me know when your recollection has been refreshed.

A. Can I read off of it or no?

MS. EGAN: Is there any objection by defense counsel?

MR. COFFEY: No.

A. I can?

Q. Yes, you may.

A. Number one was respiratory failure.

MR. COFFEY: I don't know if it's offered in evidence.

MS. EGAN: It's not in evidence. It's marked solely for ID. Do you want it offered into evidence?

MR. COFFEY: Subject to possible redaction, I have no objection.

THE COURT: What exhibit number is it?

MS. EGAN: People's Exhibit 7, Judge.

THE COURT: The People are offering it at this time?

MS. EGAN: We are offering it at this time.

THE COURT: Defendant has no objection, with the exception of possible redaction; correct?

MR. COFFEY: Correct.

THE COURT: Okay. People's 7 will be received in evidence at this time without objection.

(People's Exhibit 7 marked for identification received in evidence and marked People's Exhibit 7 in evidence.)

Q. And Dr. Kardos, would you go ahead and tell us: What was the provisional diagnosis?

A. Number one, respiratory failure; number two, leukopenia, low white blood cell count; number three, hypotension, which is low blood pressure; and number four was tachycardia and brachycardia, which is fast and slow heart rates respectively.

Q. Did you include septic shock on your provisional diagnosis?

A. No.

Q. Now, what was M[redacted]'s condition at the time he was transferred to Albany Medical Center?

A. He was critical.

MS. EGAN: I have nothing further at this time.

THE COURT: Mr. Coffey?

MR. COFFEY: Thank you.

CROSS-EXAMINATION

BY MR. COFFEY:

Q. Doctor, do you have both of those exhibits up there, 7 and 8?

A. Yes.

Q. Doctor, good morning. My name is Steve Coffey. And as you know, I represent Adrian Thomas, who is on trial today for murdering his son. You are aware of that; correct?

A. Correct.

Q. Knowing that, I want to ask you a question as a doctor. Are you here as an advocate for the District Attorney's Office?

A. No.

Q. Would I be correct that, in your role as an emergency room physician, you would be testifying to what your expertise and skill is. Would that be a fair statement?

A. Yes.

Q. So, whether the information that you provide helps or hurts Mr. Thomas or the District Attorney's Office, that is not a decision that you would make. Is that a fair statement?

A. Yes.

Q. Okay. And you have previously given testimony in this case; correct?

A. Yes.

Q. Now, let me ask you, if I can, this question: Have you met with members of the District Attorney's Office before today?

A. Yes.

Q. When was that?

A. Last week.
Q. And where did you meet?
A. In this building.
Q. All right. In their office?
A. I believe, yes.
Q. Okay. And how long did you meet with them?
A. Like 30 minutes.
Q. And who was present at that meeting?
A. Christa Book and Kelly Egan.
Q. And yourself?
A. And myself.
Q. Anyone else?
A. No.
Q. Now, you have never met with me; correct?
A. Correct.
Q. And Mr. Frost, you never met with him; correct?
A. Correct.
Q. And you never met with anybody involved at all with the defense of this case. Would that be a fair statement?
A. Yes.
Q. You never refused to meet. You just haven't met with us; correct?
A. Correct. I wasn't asked.
Q. Pardon?
A. I wasn't asked to meet with you.

Q. Had you been asked to meet, would you have met?
A. Yes.
Q. Now, at the time that you met with members of the District Attorney's Office, did you go through the medical records and the testimony that you gave previously?
A. I was given a copy of what I had done previously.
Q. Did you read it?
A. Small parts of it.
Q. Okay. And why only small parts of it?
A. Parts that I was -- parts that we had discussed, I looked at.
Q. Okay. Well, I have your testimony, but you didn't read all of it or you think --
A. No. I did not read all of it.
Q. Can you tell me why you didn't read all of it?
A. I had no reason to read it.
Q. Okay. Now, did you make notes of your conversations?
A. I made notes of things I needed to look up to get appropriate definitions.
Q. Where are those notes?
A. In my bag.
Q. Where is your bag?
A. Upstairs.
Q. In the District Attorney's Office?
A. I left it there because my computer was in there.

Q. I understand. I just --
A. Oh, yes.
Q. So, the District Attorney's Office is now holding your bag; correct?
A. Correct.
Q. Now, let me go back to this, if I can. You have indicated that you have treated over 20,000 patients?
A. Yes.
Q. Coming in through the emergency room at Samaritan?
A. Throughout my training and at Samaritan, Albany Medical Center and Samaritan Hospital.
Q. How many years have you been at Samaritan Hospital?
A. It will be eight in July.
Q. And you were board certified when?
A. I have to look back at the exact year. I believe it was 2006.
Q. So, by 2008, when M[redacted]w came into the emergency room, you were board certified then. Is that a fair statement?
A. Yes.
Q. Now, when M[redacted] was brought in, he was -- how did he arrive; do you know?
A. By ambulance.
Q. Okay. And do you recall, did you see him when he was taken out of the ambulance? Did they bring him into you? Do you recall that?

A. They brought him in. I was in the room waiting.

Q. You were in the room?

A. I was in Room 3. The ambulance arrives and wheels him into the room on the stretcher.

Q. Now, the -- when he came into the hospital, the EMT's brought him in or the paramedics, and then was his mother with them at that time, if you know?

A. I don't recall.

Q. There came a time when you talk to her; correct?

A. Yes.

Q. She identified herself as M[redacted]'s mother?

A. Yes.

Q. Now, tell me something in terms -- tell the jury. Is history important when you are treating a patient?

A. Yes.

Q. And if you were to take a history from the mother about the child, you would want to know all the significant information about what's happened to the child; correct?

A. Correct.

Q. Now, you indicated that you were in a hurry, but I want to be clear about this. You weren't in any hurry to the point where this child's care and treatment would be in any way compromised; right?

A. Correct.

Q. You weren't saying, "Come on, Mrs. Thomas. I'm in a

big hurry. It's Sunday morning. I have a lot of things to do. Move it along." You didn't say that; correct?

A. Correct.

Q. Are you hesitating or am I going in a different direction than you are going?

A. No. I'm not hesitating.

Q. So, you asked the mother what happened to the child, and she told you that he had been sick for two or three days; correct?

A. Yes.

Q. Had not been sick before that; correct?

A. Not that she stated, no.

Q. Well, you asked the question, didn't you, Doctor? "Tell me about your child." And you are there at that point as kind of a medical investigator; aren't you? You want to know what is going on with the baby; right?

A. Right.

Q. So, you said to her, the mother, "Tell me what happened." And she said he's been sick, diarrhea, some vomiting last two or three days; correct?

A. Yes.

Q. No problems before that; right?

A. Yes.

Q. Now, at that point in time, or at least up to that point in time, you made, what, a physical examination grossly

of the baby?

A. Yes.

Q. And when you looked at the baby -- I will show you the records, if you'd like. What time was it that you first came into contact with M[redacted]? Would the record show this?

A. Yes.

Q. I'm going to show you now 8 and 9. I don't know which one.

THE COURT: 7 and 8, Mr. Coffey.

MR. COFFEY: I apologize.

Q. Can I stand next to you?

A. Yes.

Q. Thanks, Doctor. Tell me if it's 7 or 8.

A. Exhibit 8.

Q. 8. Okay. What time did you first see him?

A. 9:12 a.m.

Q. All right. So, at 9:12 a.m., you saw M[redacted]. And you knew at that time that he was in trouble; right?

A. Yes.

Q. I know those aren't medical terms, but in distress or he's having difficulty; correct?

A. Yes.

Q. And at that point, you immediately ordered his blood; correct?

A. After I did the airway and breathing, yes.

Q. The ABC's; airway, breathing, circulation. Correct?

A. Yes.

Q. And the blood was taken at about what time, 9:20, 9:25?

A. I would have to look at the nurse's notes.

Q. Take a look at that, if you would.

A. It looks like 9:13.

Q. 9:13. So, would I be correct, then, in trying to determine what's going on, M[redacted] comes to the hospital at 9:12. You run the test at 9:13; correct?

A. Yes.

Q. You don't do any other blood test; correct?

A. Correct.

Q. Now, if I'm wrong -- I'm not trying to trick you. I'm really not.

A. I don't recall how many times it took to get all the blood we needed. That's not -- I put the order in. As long as the blood is collected, I don't count how many times it takes to get it. I believe they collected all the blood on the first time. I just don't know for sure.

Q. Well, let me say this, so we don't -- you don't know for sure, but unless the record indicates otherwise, we are going to take the idea that blood was taken once. Would that be a fair --

A. Yes.

Q. Agreed. So, when you take the blood at 9:13 or the blood is taken, whatever testing of that blood is done at 9:13, M[redacted] remained in the hospital for about two hours after that; right?

A. Yes.

Q. So, anything that's going on in his blood that may surface after 9:13 or 9:15, it's not going to be picked up unless there's another blood test; correct?

A. Yes.

Q. Do you agree with me?

A. Yes.

Q. Again, are you hesitant about this or not?

A. No. I'm just trying to make sure I understand your question.

Q. Well, if you take my blood right now, it will take whatever cells, whatever disease or bacteria I have; right?

A. Yes.

Q. But if at 12 o'clock, if there's a process going on and something happened between 11:30 and 12:00, it won't pick that up; correct?

A. Correct.

Q. So, therefore, if this baby were bleeding out after 9:15, this blood test would not pick that up; would it?

A. No, it would not.

Q. So, if this baby -- by the way, you learned later,

didn't you, that he developed a disseminated intravascular coagulopathy. You learned that; didn't you?

A. That I did not learn, no.

Q. If I were to tell you that the Albany Medical Center records reflect that, would you agree? You wouldn't have any reason to dispute that; would you?

A. No.

Q. And with regard to DIC -- disseminated means throughout his body; correct?

A. Correct.

Q. And when a child or a person gets disseminated intravascular coagulopathy, that bleeding occurs all through the body; doesn't it?

A. Typically.

Q. It goes in the heart, the brain, the testes for a boy? Everywhere that that blood can't clot, that's where it's bleeding; correct?

A. I believe so.

Q. Well, you told us before --

A. I gave you the definition of DIC. I actually don't see that in the Emergency Department record because it's a later finding.

Q. Fair enough. In any event, generally speaking, DIC is when the blood doesn't clot and a person -- and I'm not being demeaning to anyone. The person is actually bleeding

out; correct?

A. First they clot too much. Once those proteins are used up, they have the inability to clot because they no longer have the protein.

Q. When they infarct too much -- do you know what infarct is?

A. Yes.

Q. Can that create infarct?

A. Yes.

Q. And that's -- that can be a blockage of tissue; correct?

A. An infarct is when an area of tissue doesn't have enough blood supply and the cells begin to die.

Q. DIC is a very, very serious complication; isn't it?

A. Yes.

Q. And that blood, if it's bleeding, to your knowledge, the person can bleed in the brain, correct, because it's not clotting properly; right?

A. Correct.

Q. So, when you say that he did not have DIC, all you are saying is that the 9:13 blood test didn't pick it up at that point; correct?

A. Yes.

Q. But the 9:13 test that you did take did show a series of very serious problems with him; correct?

A. Yes.

Q. And before we get to those, let me ask you this: When you looked at the little baby, he had no bruising; correct?

A. Correct.

Q. No contusions; right?

A. Correct.

Q. No damage to his head, no openings to his head; correct?

A. Correct.

Q. Did you give him antibiotics?

A. Yes.

Q. What was that?

A. What were the antibiotics?

Q. Yes.

A. I would have to look at the chart.

Q. Sure.

A. Exhibit 7. He got Ceftriaxone and Vancomycin.

Q. Vancomycin?

A. Yes.

Q. What was the reason why those were given?

A. They are broad spectrum antibiotics, meaning they cover a very broad variety of bacteria, and we give them when someone is very ill until, if they have an infection, until the source of the infection can be narrowed down and then the

antibiotics get changed accordingly.

Q. Now, when you saw M[redacted] at nine o'clock and you started following him, he was getting progressively worse. Is that correct?

A. Yes.

Q. He was crashing?

A. Yes.

Q. Right? His blood pressure was dropping; correct?

A. Yes.

Q. What did that indicate?

A. It indicated to me that he was becoming more ill.

Q. His temperature, his temperature was dropping; correct?

A. Correct.

Q. What was that dropping down to?

A. 94.7 rectally.

Q. And a temperature of a baby that age of 94 plus is a serious condition; correct?

A. Yes.

Q. And what does that indicate to you?

A. Again, that he was becoming more ill.

Q. And what is leukopenia?

A. Low white blood count.

Q. And did you test to see his blood counts?

A. Yes.

Q. Now, Doctor, when we get sick or we have an infection, generally speaking, your white blood counts, the white blood cells, rather, will go up; won't they?

A. Yes.

Q. Because your body is generating these white blood cells to fight the infection; correct?

A. Yes.

Q. But if your white blood cells are going down, that's consistent with a problem with your body being able to produce white blood cells; correct?

A. Yes.

Q. It means you have an infection that's going through your body. It's literally taking over your body; correct?

A. Yes, it can.

Q. What part of your body produces white blood cells?

A. The bone marrow.

Q. Now, his white blood cell count had dropped to what when you saw him?

A. 1.0.

Q. And what is a normal white blood cell count?

A. Five to ten.

Q. So, he's about maybe 10 to 20 percent -- 80 to 90 percent below where he should be; correct?

A. Yes.

Q. Indicating that his bone marrow is not able to

produce enough white blood cells to fight this infection; correct?

A. Correct, can't make them quickly enough or can't produce them.

Q. It became clear to you during this morning that he was in a battle for his life and was losing it; right?

A. Yes.

Q. He also had something called aureus. Is that right?

A. I did not identify that at Samaritan. That was done at --

Q. That was done later? Were there blankets put on him?

A. I don't recall. I do remember we did put a warmer over him.

Q. Put him in a warmer?

A. We brought a warmer down from our labor and delivery to help with his body temperature.

Q. What is hypothermia?

A. A low body temperature.

Q. And was he treated for that as best you could?

A. Yes.

Q. Now, what other parts of his blood did you get the results of? We know the white blood cells were perilously low. What else?

A. We checked his hemoglobin and hematocrit, which measure the red blood cells. We checked his platelets.

Q. Platelets were low?

A. Slightly low.

Q. Slightly low. That's at 9:15; correct?

A. Yes.

Q. If those platelets were severely low -- let me withdraw that. His condition -- and I know you did everything you could do. No one is disputing that.

A. Right.

Q. But his condition from the time he came in at 9:15 to the time that he was transported to Albany Med had actually worsened at Samaritan; correct?

A. Absolutely, yes.

Q. So much so that you thought you couldn't treat him; correct?

A. Correct.

Q. So, it would be reasonable to assume, would it not, that his platelets and other things may very well have been decreasing in that two-hour period; correct?

A. Yes.

Q. His body, his entire body systems - his heart, his lungs and so forth, blood - were getting progressively worse; correct?

A. Correct.

Q. And can you tell us whether he was responsive when you first saw him at 9:15?

A. I believe, from my memory, that the only response I saw from him was he moved his legs slightly at one point.

Q. Now, his platelet count was what, 175?

A. 115,000.

Q. 150,000?

A. 115,000.

Q. The average range of a platelet count is about -- can be up to 400,000; correct?

A. 150 to 400,000, yes.

Q. All right. The white blood cell count was what?

A. 1.0.

Q. Okay. And the normal would be about 3,000 to 10,000?

A. Yes.

Q. Why is a white blood cell count important?

A. A white blood cell count can help to support your diagnosis. Your white blood cell count can change for a variety reasons. It can change due to infection, stress, pain, but it can help support a diagnosis that you have.

Q. Okay. Now, was a blood culture taken?

A. Yes.

Q. What's that called, just a blood culture?

A. A blood culture, yes.

Q. Why did you take a blood culture?

A. When looking at my differential diagnosis, sepsis or infection was on my differential. So, it was in my thoughts.

And part of evaluating somebody for an infection includes taking a blood culture.

Q. Now, let's talk about your differential diagnosis. When a person comes into the hospital, an adult or child, every doctor, such as yourself, a board certified physician, will kind of process in their own mind what is it that is causing this? A person has chest pain. It could be a hard attack, indigestion. It could be a number of things; correct?

A. Yes.

Q. Okay. And you have done this. In fact, you still do it every day of your life; correct?

A. Yes.

Q. So, when he came in and you talked to the mom and you looked at him and you did all your tests, your differential diagnosis had three, but the one that you really came to the conclusion of was it was sepsis; correct?

A. I didn't come to a conclusion.

Q. Well, you actually have come to a conclusion at some point in time; haven't you?

A. No.

Q. Well, I'm going to read you your testimony from before, Doctor. You may not have read this. You actually had been asked a question previously as to what do you think was the cause of what happened to this baby, and you gave an opinion. Do you recall being asked that question and giving

that answer?

A. Yes.

Q. Okay. But what is sepsis?

A. Sepsis is a probable or documented infection in the body that produces a systemic response.

Q. Systemic meaning what?

A. Like a whole body response. It typically starts with inflammation and then progresses from there.

Q. Okay. And in your differential diagnosis, you listed sepsis or septic shock as part of your differential diagnosis; correct?

A. Yes.

Q. And why was that?

A. Because when the child came in, he had abnormal vital signs. He had a reported history of having vomiting and diarrhea, reported history of having an elevated temperature. During his stay in the ER, his temperature was going down. So, I included a source of infection as a possible diagnosis.

Q. Well, septic shock is not just a source. Septic shock is taking over the system; correct?

A. Sepsis is the probable or documented infection. Septic shock is when you have low blood pressure associated with that.

Q. Rapid heart rate, low blood pressure, hypothermia, leukopenia. All consistent with sepsis; correct?

A. Yes.

Q. Now, what happens when your body gets septic shock?

A. You have many inflammatory mediators released, toxins get released and they start to infect all different organs in your body.

Q. And you came up with a provisional diagnosis; correct?

A. Yes.

Q. And tell us again what a provisional diagnosis is?

A. It's a diagnosis that we come up with in the Emergency Department when we have only limited time and limited data to work with.

Q. All right. Now, your provisional diagnosis for this baby was respiratory failure, leukopenia, hypotension, tachycardia and brachycardia; correct?

A. Yes.

Q. And these conditions, are they caused by sepsis?

A. Yes.

Q. You found no evidence whatsoever, from your analysis or your review - and I understand you were preliminary - of any trauma to this baby; correct?

A. Correct.

Q. And Doctor, is it true that the likely cause of this baby's problems was sepsis?

A. Yes.

Q. So, as you sit here today, you would agree that the likely cause of his problems was sepsis; correct?

A. With the information that I had that day, yes, absolutely.

Q. Well, as you sit here today, you agree that the likely cause was sepsis; correct?

A. Yes.

Q. Now, do you know what Gram staining is?

A. Yes.

Q. What does it mean to Gram stain something?

A. It's when you take, in this case, the patient's blood and you use different kinds of dye to see if you can identify the presence or absence of bacteria in different cells.

Q. And what is bacteremia?

A. Bacteremia? The presence of bacteria in the blood.

Q. And how does bacteria get in the blood?

A. Through a break in the skin or the mucosal surface of the body.

Q. So -- and bacteria -- let me ask you a little bit about this in terms of -- I use the word pyramid. You take kids in a day care center or, say, a class of 20 kids. A bunch of those kids will have some kind of a staphylococcal pneumonia; right?

A. Staphylococcal is a common pneumonia.

Q. That's a common bacteria; correct?

A. Correct.

Q. Now, a lot of kids will get that and it won't be a problem; correct?

A. Correct.

Q. A few more may get that and it may -- they may get sick or they may get a fever; right?

A. Yes.

Q. And some others may get it and they get pneumonia, because it gets in the lungs; correct?

A. Correct.

Q. And of course, there's less and less as we go up the ladder. And then you can get some where it will get more serious, where bacteremia gets in the blood. And that's not good; is it?

A. No.

Q. That has to be treated with antibiotics; correct?

A. Correct.

Q. Because if bacteremia gets in the blood and it starts spreading throughout the blood, it can ultimately cause sepsis, infection in the blood, and then it can go racing through the body; correct?

A. Correct.

Q. And the way it gets in the blood, from your experience, is an open wound; correct?

A. That's one way, yes.

Q. I mean, if a child, for example, has an opening on the cheek and a break in the skin, it could get in through there possibly; right?

A. Yes.

Q. And through the lungs; correct?

A. Yes. Sometimes we don't know, yes.

Q. Have you ever treated children with bacteremia before?

A. Yes.

MR. COFFEY: May I have one minute?

THE COURT: Yes, you may.

(Brief pause in proceedings.)

Q. Doctor, let me ask you -- I asked you some questions before about DIC. You are not an expert on DIC; correct?

A. Not at all.

Q. Not at all?

A. Not at all.

Q. I want to ask you about aspiration. There's no evidence whatsoever that this child ever aspirated anything. Is that correct?

A. Not while he was in my care, no.

Q. Well, you have no evidence of any history of him having aspirated anything; correct?

A. Correct.

Q. You did a lung -- x-rayed the lungs?

A. Chest x-ray, correct.

Q. Chest x-ray. And that shows the lungs; correct?

A. Correct.

Q. No evidence of any particles or anything in his lungs; correct?

A. Correct.

Q. All right. Now, the reason why he got transferred to Albany Med is why, because Albany Med's CAT scans are more -- did they have CAT scans at Samaritan?

A. Yes.

Q. But Albany Med had more specific CAT scans or MRI's, something like that?

A. No. If I may answer, the reason he got transferred is because we don't have a Pediatric Intensive Care Unit at Samaritan Hospital. We don't have the ability to care for a child this ill.

Q. All right. Now, the antibiotics was appropriate for treating someone with sepsis; correct?

A. Yes.

Q. And that is what you were working under; correct?

A. That was one of the differential diagnoses, yes. I didn't have all my data back, so I was treating all the differentials.

Q. Well, now you have all the data back?

A. We were unable to get a CAT scan at our hospital. I

was treating the dehydration. I was treating potential sepsis. Unfortunately, he was too unstable to go to our CAT scanner. So, we got him to the facility where he needed to be where they were able to do everything else.

Q. When you looked at him, you looked all through his -- externally, you looked at his head, his body and so forth; correct?

A. Yes.

Q. There were no external injuries at all; correct?

A. Correct.

Q. No bruising to his head, his ribs, arms or legs; correct?

A. Correct.

Q. You saw no fractures; correct?

A. Correct.

Q. There were no -- tell the jury the difference between objective and subjective signs or objective and subjective parts of medicine?

A. Subjective is like -- maybe more interpretative, something we have to interpret; whereas objective is something that is black or white or can be proved.

Q. So, my temperature, whatever it is, 98.6, that's subjective?

A. Yes.

Q. If you were to say you were getting a headache

talking to me, that would be subjective; correct?

A. Subjective, correct.

Q. Now, there were no objective signs at all that you found of any trauma to this baby; correct?

A. Correct.

Q. The history of the diarrhea that you received from Mom was within the last two or three days; correct?

A. Correct.

Q. In fact, in your report or in the medical report, it's specific, two or three days; correct?

A. Correct.

Q. You wouldn't have guessed at that. That's what she told you; correct?

A. If I could look at it again. I documented what she told me.

Q. Sure.

A. I have that the mom states the patient has been having diarrhea for, quote, a few days.

Q. All right. Let me -- I'm going to show you what's part of Exhibit Number 8, "diarrhea for two or three days." See the "two or three days"?

A. That's the nursing documentation.

Q. That's not the history provided to you?

A. No. That is what the nurse received. This is what I received.

Q. Okay. You list a provisional diagnosis of respiratory failure, leukopenia, hypotension, tachycardia and bradycardia; correct?

A. Yes.

Q. Now, is a provisional diagnosis more defined than a differential diagnosis?

A. Yes.

Q. It is; correct?

A. Correct.

Q. You have more information at that point?

A. It's based on the data that I have at that point.

Q. So, when M[redacted] left the hospital, that was your diagnosis at that point; correct?

A. Correct.

Q. And all of those things were consistent with septic shock; right?

A. Correct.

MR. COFFEY: One minute, if I might. That's all I have, Judge. I have something I want to address with you later, but that's all I have at this point.

THE COURT: Ms. Egan, any redirect?

MS. EGAN: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. EGAN:

Q. I'm just going to grab Exhibit 7 and 8. Dr. Kardos,

do you always take an in-depth medical history of patients in the ER?

A. No.

Q. Why is that?

A. We take the best history we can based on how ill the patient is.

Q. Now, did M[redacted] require constant care while he was at Samaritan?

A. Yes.

Q. Did you see any signs of open wounds on M[redacted]?

A. No.

Q. Did you see any signs of infection externally on M[redacted]?

A. No.

Q. Now, what are external signs of bleeding out?

MR. COFFEY: Objection. I didn't ask that question. I believe she was asked that on direct.

MS. EGAN: Judge, I believe Mr. Coffey did talk about a patient bleeding out.

THE COURT: The objection is overruled.

Q. Thank you. What external signs would you expect to see if a patient is bleeding out?

A. You would expect to see easy bruising, excessive bleeding from any break in the skin, a patient becoming pale.

Q. Did you see any of those external signs in M[redacted]

while he was in your care?

A. No.

Q. Would you expect to see bleeding at an IV site if the patient were experiencing internal bleeding?

A. If it was severe enough, yes.

Q. Now, did the mother report to you that M[redacted] had also been vomiting the past few days?

A. Yes.

Q. Can an infant aspirate after he vomits?

A. Yes.

Q. Do you see signs of an aspiration pneumonia immediately after someone aspirates?

MR. COFFEY: Object to this as far beyond her direct and cross.

MS. EGAN: Judge, I believe this is well within cross. He discussed aspiration and whether M[redacted] had aspirated.

THE COURT: The objection is overruled.

A. Can you repeat the question?

Q. Do you see signs of aspiration pneumonia immediately after someone has aspirated?

A. No.

Q. About how long would it take to develop?

A. It can take one to several days.

MS. EGAN: If I could just have one moment,

Judge.

THE COURT: Sure.

Q. Was M[redacted]'s urine output being monitored?

A. Yes.

Q. Was any blood noted in his urine?

A. There was no gross blood. I would have to look at the urinalysis to see if there was any microscopic blood.

Q. Would that be in People's Exhibit 8? I can hand you the exhibit and you can let me know.

MS. EGAN: May I approach?

THE COURT: You may.

A. It would actually be -- yes. I believe it is in here. There was no gross blood, meaning that you couldn't see it in the bag it was collected in, and there was trace blood in the -- trace microscopic blood, which is not uncommon when you put a catheter in somebody.

Q. Is that consistent with a patient experiencing severe internal bleeding, to see trace blood? Let me rephrase that. Let me withdraw that question. Would you expect to see blood in the urine if a patient were experiencing severe internal bleeding?

A. Yes.

Q. The items listed in your provisional diagnosis, are any of those consistent with head injury? And I can hand you the exhibit if you wanted to refer to that again.

A. Head injury encompasses such a broad --

MR. COFFEY: I object. She was asked a simple question. It's either yes or no.

THE COURT: The objection is overruled.

A. What does that mean?

Q. You can answer that.

THE COURT: Doctor, do you understand the question?

THE WITNESS: Not really. I mean --

Q. I will withdraw the question and I will rephrase. Do you see respiratory failure in patients with head injury?

A. With severe head injury, yes, you can.

Q. Can you see hypotension in patients with severe head injury?

A. Yes.

Q. Can you see tachycardia and bradycardia in patients with severe head injury?

A. Yes.

Q. Can you see leukopenia in patients with severe head injury?

A. Yes.

Q. And at the time you discharged M[redacted], did you have the benefit of a CAT scan in making your provisional diagnosis?

A. No.

Q. And was your opinion regarding sepsis being a source

of M[redacted]'s problems given with the benefit of any sort of CAT scan?

MR. COFFEY: Object as leading.

A. I did not have a --

THE COURT: Hold on one second. I'm just considering the objection. The objection is sustained.

MS. EGAN: Can I have one minute, Judge?

THE COURT: Sure.

(Brief pause in proceedings.)

MS. EGAN: I have nothing further, Your Honor.

THE COURT: Mr. Coffey, anything else?

MR. COFFEY: Yes.

RECROSS-EXAMINATION

BY MR. COFFEY:

Q. Doctor, you have examined 20,000 patients; correct?

MS. EGAN: Objection. Withdrawn.

Q. Is that correct?

A. At the time of this case, yes. It's been more since then.

Q. Maybe 40,000 by now. Is that correct?

A. Yes.

Q. You know what the signs and symptoms of head trauma are; don't you?

A. Yes.

Q. And Doctor, other than the fact of your provisional -

actually, your differential diagnosis - you never, ever, ever come to the conclusion that this baby suffered injury as a result of trauma. You never expressed that opinion; have you?

A. No. I have never expressed that opinion.

Q. Your opinion is that the baby's injuries were consistent and caused by septic shock; correct?

A. With the information I had at that time, correct, yes.

Q. Well, 40,000 patients is a lot of experience; isn't it, Doctor?

A. It is. I didn't have all of my data; but at that point, absolutely, yes.

Q. And you are not an expert in DIC; are you?

A. No.

Q. And at the time that the IV was placed and the catheter in this little baby's -- in his penis, I assume; correct?

A. Yes.

Q. If he developed DIC during the time he was in the hospital, you are not prepared to say he didn't have DIC when he left; are you?

A. No.

Q. And let me ask you about this aspiration. I want you to assume that the mother has testified in this case and was specifically asked if there was any vomiting over --

MS. EGAN: I'm going to object to discussion of another witness' testimony.

THE COURT: The objection is overruled.

Q. She said she never -- she never testified about any vomiting. And in the report by the EMT's, the mother never said anything about vomiting. You say you have a history of some vomiting that weekend?

A. Yes.

Q. Would I be correct that, when you take a history, you are pretty careful?

A. Yes.

Q. When you are taking a history from me as a parent and you have a child there, you don't stand there with your back to the mother mumbling. You look in their eyes and say, "Tell me what happened to your baby." Right?

A. Yes.

Q. Because a four-month-old, even healthy, can't give a history; right?

A. Yes.

Q. And she told you that the only history that was significant was that over the weekend - this is a Sunday - the past couple of days, he had some vomiting and some diarrhea; correct?

A. Correct.

Q. Nothing before that date; correct?

A. Correct.

Q. And you asked: "Tell me what was going on with your baby." Right?

A. Yes.

Q. And that's what she told you; correct?

A. Yes.

MR. COFFEY: That's all I have.

THE COURT: Ms. Egan, anything else?

MS. EGAN: Can I just have one moment, Judge?

THE COURT: Yes.

REDIRECT EXAMINATION

BY MS. EGAN:

Q. Dr. Kardos, have you ever seen signs of intracranial head injury in an infant?

MR. COFFEY: Object to this as outside the scope of my recross.

MS. EGAN: Judge, he asked specifically about head trauma.

MR. COFFEY: I asked because she asked on direct. I'm sorry, Judge.

THE COURT: The objection is overruled. I will allow the question; and you can, of course, follow up on recross if you'd like.

Q. In your experience, have you ever treated an infant with intracranial head injury without any corresponding

external signs?

A. Yes.

MS. EGAN: I have nothing further.

RECROSS-EXAMINATION

BY MR. COFFEY:

Q. So, having treated children with intracranial head injuries -- and you have treated those; correct?

A. Correct.

Q. And even with all that, today, as you sit here, based upon the information that you knew, you are still adhering to your diagnosis that this baby had sepsis and that was the cause of his problems; correct?

A. When he left the ER, with my knowledge, yes.

MR. COFFEY: That's all I have.

THE COURT: You may step down.

MR. COFFEY: May we approach the bench?

THE COURT: Yes. On the record?

MR. COFFEY: No.

(Discussion off the record.)

THE COURT: Members of the jury, we are going to break for lunch at this point in time. It's about five after 12, so we will break until 1:05. During the course of this lunch break, please do not discuss the case among yourselves or with anyone else. Do not read or listen to any media accounts of this case. Do not visit or view any

premises mentioned here. Do not conduct any research about this trial. Do not accept or request any payment in return for supplying any information about this case. Do not form any judgments or opinions about this case. If anyone attempts to improperly influence you, please report that directly to me. Enjoy your lunch. We will see everyone back here at 1:05. Thank you.

(Jury excused.)

THE COURT: Please be seated. Doctor, I believe your testimony is completed. I'm not completely certain of that yet, though, because during this break, the defense is going to review your notes and make a determination as to whether they have any additional questions for you. The attorneys will let you know during the lunch break whether that is, in fact, the case or not. If they determine that there's no further questions, you will be excused at this time, at that time. If the defense determines that they do have additional questions, then you will be expected to -- you will be advised of that and you will be expected to be back here at 1:05 to complete your testimony. Okay. Do you understand that?

THE WITNESS: Yes.

THE COURT: And because there is still a chance that you may be giving further testimony, I will direct that during the break, until such time as you are advised

that your testimony is completed, that you please don't discuss this case or your testimony with anyone, including the attorneys. To the extent that you need to communicate with the DA's Office to show them where your notes are, you may do that, but don't have any additional discussions about this case or your testimony. Okay?

THE WITNESS: Where do I wait?

THE COURT: Well, off the record.

(Discussion off the record.)

(Whereupon, a luncheon recess was taken.)

(Proceedings continue outside the presence of the jury as follows:)

THE COURT: Please be seated. Thank you. We will go on the record. Before we proceed with the jury, Mr. Coffey, did you have a chance during the lunch break to review Dr. Kardos' notes?

MR. COFFEY: Thank you, Judge. I did, and we told the District Attorney's Office that we had no need to bring her back. We are fine.

THE COURT: Thank you. Are the People ready to proceed with the jury?

MS. BOOK: Yes, Your Honor. I just briefly wanted to mark three things that I believe we are going to stipulate in. I'm sorry, four things. That would be the St. Mary's Hospital certified records of M[redacted] and